CAFETERIA PLAN ENROLLMENT FORM

Company Name: _____

Employee Name: _____

Address: _____

Phone: _____

Date of Birth: _____/_____/_____

Social Security Number: _____-_____- _____ **Participant ID:** _____

Effective Date: _____/_____/_____

Benefit: Please Check All that Apply	Monthly Premium	X Months left in the Plan Year	Equals Annual Election	Divided by # Pay Periods Left in Plan Year	Equals Pre-Tax Per Pay-Period	Equals Post-Tax Per Pay-Period
TOTAL -						

o **I decline participation in the Cafeteria Plan. I understand that I may not enroll for the remainder of this Plan Year, unless I have a "Change in Status" as defined by the IRS Rules and Regulations and the Plan Document.**

If you have any questions, please feel free to contact _____

BCI Benefit Consultants Insurance Group, LLC
"A Policy of Service"

P.O. Box 7
Fort Edward NY 12828
Phone: 518-338-3500
Fax: 518-338-3502

CAFETERIA PLAN ENROLLMENT FORM

Employee Name _____ **Social Security Number** _____/_____/ _____

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I hereby authorize my Employer to reduce my cash compensation as indicated above, for each pay period during the year following the date of this agreement. I understand that I will **NOT BE ABLE TO CHANGE** my benefit ELECTIONS during the plan year unless I have a "change in status." I understand that the insurance premium(s) elected must be approved by the issuing company and my insurance election(s) will **only** change when there is a change in the premium by the insurance company. I understand that benefits provided to me tax-free SHOULD NOT BE USED as credits or deductions ON MY PERSONAL income TAX RETURN.

_____	___/___/ ___	_____	___/ ___/ ___
Participant's Signature	Date	Employer Signature	Date

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Please fax to: 518-338-3502